06489

MARYLAND — **STATE DEPARTMETT OF HEALTH**

6436

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (in this place): 2 y 8 m 18 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frederick
10-11-2
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): Dorothy (First) Viola (Middle) Baxter (Last)

4. DATE OF DEATH: (Month) 7 - (Day) 9 - (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 10 - 15 -87

9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days / If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Krise

14. MOTHER'S MAIDEN NAME: Mary Willhime

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause (a) Diabetic gangrene of left leg — Interval between onset and death: 3 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic cardiovascular disease — years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Chronic brain syndrome assoc. with arteriosclerotic circulatory disturbance with psych. reactions — years

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-5-53, to 7-8-55, that I last saw the deceased alive on July 8, 1955, and that death occurred at 4.15 a.m., from the causes and on the date stated above.

SIGNATURE (Doctor or title): Edmund Lusthaus M.D. — ADDRESS: Springfield State Hospital — DATE SIGNED: July 9, 55

Edmund Lusthaus, M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 7/11/55 — NAME OF CEMETERY OR CREMATORY: Blue Ridge Cem. — LOCATION (City, town, or county): Thurmont Md. — (State)

DATE REC'D BY LOCAL REG.: July 10, 1955 — REGISTRAR'S SIGNATURE: C. Harry Eiker

24. FUNERAL DIRECTOR: M. L. Creager & Son — ADDRESS: Thurmont Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06490

6487

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville, Md.
LENGTH OF STAY (in this place) 2½ y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springf. State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4
STREET ADDRESS (If rural give location) 3711 Egerton Road

3. NAME OF DECEASED (Type or Print): (First) Lillian (Middle) Auor (Last) Bennett

4. DATE OF DEATH: (Month) 7 (Day) 22 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: 8-28-1871

9. AGE last birthday 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Dover, Delaware

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Aaron Satterfield

14. MOTHER'S MAIDEN NAME: Sarah Anne Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X

IMMEDIATE CAUSE (A) Cardio Vascular Accident — 10 days

ANTECEDENT CAUSE (B) — DUE TO (B) Cerebral Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Senile Psychosis

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-31, 1951, to 7-22, 1955 that I last saw the deceased alive on 7-22, 1955, and that death occurred at 1050 P.M, from the causes and on the date stated above.

SIGNATURE Gertrud Sonnenfeld M.D. ADDRESS Springfield State Hospital Sykesville Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 7/25/55 — NAME OF CEMETERY OR CREMATORY Woodlawn — LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR 7/26/1955 — REGISTRAR'S SIGNATURE C. Harry Wurz — 24. FUNERAL DIRECTOR Wm J Tickner & Sons Inc — ADDRESS Wkly Blvd

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

Item 21a Film G184 8-9-55 ams

06491

6488

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Carroll; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (in this place): 6yr. 10mo. 22days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 7
STREET ADDRESS (If rural, give location): 5207 Overcrest Avenue

03X-2

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	FREDERICK	BOWERS	July	31	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday: If under 1 year Months	Days	If under 24 hrs Hours	Min.
Male	White	Married	9-10-90	64 yrs.			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman - retail	Floor Coverings	Maryland	U.S.A.

13. FATHER'S NAME: George Bowers
14. MOTHER'S MAIDEN NAME: Theresa Louisa Romoser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		213-09-4587	Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

903.7

Immediate cause (a) Cerebral embolism pending further examination. — Interval Between Onset and Death: Instantly

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of the Prostate Gland — 12 months+

(c) Embolism of left Lung, due to — Minutes

(d) Fracture of left femur. — 3 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis. — 7½ yrs.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Hospital	Sykesville	Carroll	Md.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR?
7-28-55 m.		Fell in bathroom.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James I. Marsh	M. D.	Westminster Md	7/31/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 3 1955	Loudon Park Cemetery	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-2-55	Helen Hedrick	Wm. J. Tickner & Sons,	Balto. 17, Md.

Dmw

MARYLAND

06492

STATE DEPARTMETT OF HEALTH

6489

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (in this place): 2mths 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balto City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1804 Spence Street

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Frank	Richardson	Burrell, Sr.	7	23	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs: Hours	Min.
M	W	married	9-22- 84	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
guard	Brass & Copper	New York	U.S.A.

13. FATHER'S NAME: R. Frank Burrell

14. MOTHER'S MAIDEN NAME: Sara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
unk No		215-10-0864 unkn	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1

Immediate cause (a) Cerebral hemorrhage — 2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic cardiovascular disease — years

(c) Chronic cystitis with prostatic hypertr. benign — 2½ months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chr. brain syndr. ass. with cerebral arteriosclef. — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 2, 55 to July 23, 1955, that I last saw the deceased alive on July 22, 55, and that death occurred at 4:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Edmund Lusthaus M.D. — ADDRESS Springfield State Hospital — DATE SIGNED July 23, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/26/55	Loudon Park	Baltimore

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-26-55	[signature]	Wm J Tasker & Son	Notary

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06493

6490

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (27) 03.51-2
STREET ADDRESS (If rural give location) 7000 Highland Ave.

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Henry (Last) Burrier

4. DATE OF DEATH: (Month) 7 (Day) 23 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: 3-28-77

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours —, Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): painter

10B. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lewis H. Burrier

14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. ----------

17. INFORMANT & ADDRESS: 7000 Highland Ave. Balto., Md. George Hood

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Acute myocardal infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) conorary arteriosclerosis — years

DUE TO chronic brain syndorme with

(C) cerebral arteriosclerosis — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 7

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-24, 1955 to 7-23, 1955 that I last saw the deceased alive on 7-23, 1955, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

SIGNATURE A. Lubizka — ADDRESS M.D. Springfield State Hosp. Maryland — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF July 26 55 — NAME OF CEMETERY OR CREMATORY Loudon Pk. — LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR 7-26-55 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR Harry H. Lutzke — ADDRESS 4101 Edmondson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6491

CERTIFICATE OF DEATH

Reg. Dist. No. 78

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Rural
LENGTH OF STAY (in this place) Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Enterprize

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Rural
STREET ADDRESS (If rural give location) Enterprize

3. NAME OF DECEASED: (Type or Print) (First) EDWARD (Middle) M (Last) BYERS

4. DATE OF DEATH: (Month) July (Day) 9 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: Oct 23 1876

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Byers

14. MOTHER'S MAIDEN NAME: Cinder Byers

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Wilbur Null, Westminster R5 Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cerebral Sclerosis

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 5, 1955, to July 9, 1955, that I last saw the deceased alive on July 7, 1955, and that death occurred at 2 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. H. Legg M.D. ADDRESS Pleasant Valley Md DATE SIGNED 7-9-55

23. BURIAL, CREMATION, REMOVAL (Specify) buried DATE THEREOF July 11 1955 NAME OF CEMETERY OR CREMATORY at home LOCATION (City, town, or county) Carroll Co. (State) Md

DATE REC'D BY LOCAL REGISTRAR 7-9-55 REGISTRAR'S SIGNATURE E. M. Fowler

24. FUNERAL DIRECTOR H. Hartzler & Sons ADDRESS New Windsor Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6492

CERTIFICATE OF DEATH

06495

Reg. Dist. No. 26

MAIGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: X Rural Westminster
LENGTH OF STAY (in this place): 16 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.D. 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Westminster
STREET ADDRESS (If rural give location): R.D. 2

3. NAME OF DECEASED: (Type or Print) (First) JESSE (Middle) W. (Last) BYERS

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: May 25, 1880

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Cabinet Maker + builder

10b. KIND OF BUSINESS OR INDUSTRY: self employed

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Byers

14. MOTHER'S MAIDEN NAME: Annie M. Crowl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 214-01-1700

17. INFORMANT & ADDRESS: Alice M. Byers Westminster, Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause	(a) Acute Coronary Artery Occlusion	2 hrs.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Coronary Arteriosclerosis	10 yrs.
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized Arteriosclerosis	10 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1939, to July 2, 1955, that I last saw the deceased alive on July 2, 1955, and that death occurred at 4:15 P.M. E.S.T. from the causes and on the date stated above.

SIGNATURE (Degree or title): R. B. McVaugh M.D. ADDRESS: Taneytown Md. DATE SIGNED: 7/4/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: July 5 1955 — NAME OF CEMETERY OR CREMATORY: Woodbine Cemetery — LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: July 5, 1955 — REGISTRAR'S SIGNATURE: Hannah Fuller

24. FUNERAL DIRECTOR: H. Bankard Son — ADDRESS: Westminster Md.

VS. A15

6493

06496 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR X TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 526 - 1 mi. ea. of Westminster

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westminster, Md. 27
STREET ADDRESS 27 (If rural, give location) 1 Uniontown Road

3. NAME OF DECEASED: (Type or Print) (First) MARSHALL (Middle) GRANT (Last) CARR

4. DATE OF DEATH (Month) July (Day) 19 (Year) 19 55

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: ?
9. AGE last birthday: 70 + yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lemuel Carr
14. MOTHER'S MAIDEN NAME: Catherine Gamble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: George W. Carr, Uniontown, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Crushed chest
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Ruptured aorta
DUE TO
(c) Massive hemothorax

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ cause OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street
21c. (City or town) (County) (State) 1 mile east of Westminster - Carroll Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 7/19/55 10:15 M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☒
21f. HOW DID INJURY OCCUR? Struck by auto

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE William Smith M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF July 22 55
NAME OF CEMETERY OR CREMATORY Salem Cemetery
LOCATION (City, town, or county) (State) Rural, Westminster, Md.

DATE REC'D BY LOCAL REG. 7-21-55
REGISTRAR'S SIGNATURE Hamit Miller
24. FUNERAL DIRECTOR ADDRESS J. E. Myers, Jr. Funeral Director Westminster, Md.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06497

6493 **CERTIFICATE OF DEATH** Reg. Dist. No. 78

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural- Mt. Airy
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural--Mt. Airy X
STREET ADDRESS (If rural give location) Buffalo Road 1

3. NAME OF DECEASED: (Type or Print) (First) RUFUS (Middle) Z. (Last) CHAMPION

4. DATE OF DEATH. (Month) July (Day) 28, (Year) 19 55

5. SEX male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married | 8. DATE OF BIRTH: 8-24-1890 | 9. AGE last birthday 64 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired fireman | 10B. KIND OF BUSINESS OR INDUSTRY: Balto. Fire Dept. | 11. BIRTHPLACE (State or foreign country): North Carolina | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Champion | 14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. none | 17. INFORMANT & ADDRESS: Mrs. Azalia E. Champion, Same

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

59 2X IMMEDIATE CAUSE (A) Acute Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Chronic Nephritis — 6 years
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 11 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/26, 19 55, to 7/28, 19 55 that I last saw the deceased alive on 7/27, 19 55, and that death occurred at 1 A.M, from the causes and on the date stated above.
SIGNATURE Reuben Baer M.D. ADDRESS Westminster, Md. DATE SIGNED 7/28/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 8-31-1955 | NAME OF CEMETERY ~~OR CREMATORY~~ Winfield Church of God | LOCATION (City, town, or county) (State) Carroll Co., Maryland

DATE REC'D BY LOCAL REGISTRAR 7-29-1955 | REGISTRAR'S SIGNATURE E. M. Farver | 24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06498

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6495

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Klokville
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Klokville X
STREET ADDRESS (If rural give location) Hyksville P. O. 1

3. NAME OF DECEASED: (Type or Print) (First) Riddie (Middle) D. (Last) Clingston
4. DATE OF DEATH: (Month) July (Day) 4 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F.	W	Married	Nov. 26, 1885	69 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Md.	U.S.A.

13. FATHER'S NAME: Abraham F. Dehart
14. MOTHER'S MAIDEN NAME: Mary E. Dansberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	—	Unk-	Mr. Jesse F. Clingston, Hyksville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/20/, 1955, to 7/4/, 1955, that I last saw the deceased alive on 7/4/, 1955, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

SIGNATURE AND M.D. Wm. E. Martin ADDRESS Randallstown DATE SIGNED 7/6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-7-55	Springfield	Hyksville, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
July 6 1955	C. Harry Deer	Smith H. Haight Hyksville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06499

6496

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 48 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 5

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural give location) R.D. 5

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) WILLIAM (Last) COPENHAVER

4. DATE OF DEATH: (Month) July (Day) 4 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 11-1906

9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Clothing Factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Tilden Copenhaver

14. MOTHER'S MAIDEN NAME: Catharine Leffert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 213-05-1517

17. INFORMANT & ADDRESS: Kathryn Koontz Copenhaver R.D. 5 Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of kidney, met. to liver & R lung. — Interval Between Onset And Death: about 1 yr

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Myocarditis — 4 yrs
DUE TO (c) Nephritis — 1 yr.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... ,1955, to 7-4-, 1955, that I last saw the deceased alive on 7-4-, 1955, and that death occurred at 11 am., from the causes and on the date stated above.

SIGNATURE (Degree or title) W C Jamuth MD ADDRESS 103 E Main Westminster Md DATE SIGNED 7-5-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF July 6 1955 NAME OF CEMETERY OR CREMATORY St. Marys Cemetery LOCATION (City, town, or county) (State) Silver Run Md.

DATE REC'D BY LOCAL REGISTRAR 7-5-55 REGISTRAR'S SIGNATURE Francis Anda

24. FUNERAL DIRECTOR A.H. Bankard Son ADDRESS Westminster, Md.

MARYLAND

STATE DEPARTMETT OF HEALTH

6497 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carrol — MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville; LENGTH OF STAY (in this place) 34 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Montgomery COUNTY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 15-2m-E; STREET ADDRESS (If rural, give location) 205 Park Road

3. NAME OF DECEASED (Type or Print): (First) EDYTH (Middle) MILTON POTTS (Last) CRIM

4. DATE OF DEATH: (Month) July (Day) 9, (Year) 55

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorsed

8. DATE OF BIRTH: 1-5-05

9. AGE last birthday: 50 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Housekeeper

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clinton Potts

14. MOTHER'S MAIDEN NAME: Mary — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): NIL

16. SOCIAL SECURITY NO.: Unk-

17. INFORMANT AND ADDRESS: Ariel Crim - son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 491X BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last: (b) ..... (c) (260X)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

1.) Diabetes Mellitus
2.) Hypertensive Cardio-Renal Disease
3.) Psychotic Reaction sec. to Arteriosclerosis

years years

19a. DATE OF OPERATION: NIL

19b. MAJOR FINDINGS OF OPERATION: NIL

20. AUTOPSY? Yes ☐ No X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NIL

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: NIL

(CITY OR TOWN) (COUNTY) (STATE): NIL

TIME OF INJURY (Month) (Day) (Year) (Hour): NIL m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? NIL

22. I hereby certify that I attended the deceased from 6-6 ..., 1955.., to 7-9 ..., 19.55., that I last saw the deceased alive on 7-9 ..., 1955..., and that death occurred at 11:02 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H. Sommerfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 7-9-55

23. [illegible] REMOVAL (Specify): DATE 7-10-55 NAME OF CEMETERY OR CREMATORY Bethesda, Md. LOCATION (City, town, or county) (State) Bethesda, Md

DATE REC'D BY LOCAL REG. July 10, 1955 REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR Robert A. Dempsey ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

06501

6482

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 27 Westminster
MARYLAND
LENGTH OF STAY (In this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 19 Pine St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Minster 27
STREET ADDRESS (If rural, give location) 19 Pine St

3. NAME OF DECEASED (Type or Print): (First) BERTHA. (Middle) IRENE (Last) DRACH

4. DATE OF DEATH: (Month) July (Day) 14 (Year) 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: Mar 7 1894

9. AGE last birthday: 61 yrs. | If under 1 year: Months | Days | If under 24 hrs: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Ingrd

11. BIRTHPLACE (State or foreign country): Carroll Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John E Drach

14. MOTHER'S MAIDEN NAME: Flora Fleet

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-07-7425

17. INFORMANT AND ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Minutes

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy __, Inspection X, Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident __, suicide __, homicide __, undetermined __.*

SIGNATURE: [illegible] (Degree or title) Deputy Medical Examiner ADDRESS: [illegible] MD DATE SIGNED: 7/14/57

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF July 17-1955 | NAME OF CEMETERY OR CREMATORY Pine Hill Cem. | LOCATION (City, town, or county) (State) Carroll Co, Maryland

DATE REC'D BY LOCAL REG. 7-16-57 | REGISTRAR'S SIGNATURE Harriet Miller

24. FUNERAL DIRECTOR: D D Hartless & Sons | ADDRESS: New Windsor

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06502

6493

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 22 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY —
CITY. If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3 Vc 1-4
STREET ADDRESS (If rural give location) 2443 Shirley Ave

3. NAME OF DECEASED (Type or Print): (First) Louis (Middle) — (Last) Dubois

4. DATE OF DEATH: (Month) July (Day) 2nd (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 1906? June 2.

9. AGE last birthday: 49 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10B. KIND OF BUSINESS OR INDUSTRY: Tailor Shop

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Dubois

14. MOTHER'S MAIDEN NAME: Ida Collin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. ???? Unk.

17. INFORMANT & ADDRESS. Records of Springfield State Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Hypertensive cardiovascular disease more — more than 20 yrs

(C)

II. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. schizophrenia, hebephrenic type — 22 yrs

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Spt. 1 , 1947 , to July 2 , 1955 , that I last saw the deceased alive on July 2 , 1955 , and that death occurred at 10:10 P.M. from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. M.D. ADDRESS Sykesville, Md DATE SIGNED July 3, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 7-5-55

NAME OF CEMETERY OR CREMATORY Beth Isaac

LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR July 4, 1955

REGISTRAR'S SIGNATURE J. Harry Tawes

24. FUNERAL DIRECTOR Jack Levis, Inc. ADDRESS 210 Eastern Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06503

6493

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hampstead
LENGTH OF STAY (in this place) 6 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Hampstead R D #2

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hampstead R.D. 2 X
STREET ADDRESS (If rural give location) Hampstead R D #2 1

3. NAME OF DECEASED (Type or Print): (First) TOBIAS (Middle) HENRY (Last) DUBS

4. DATE OF DEATH: (Month) July (Day) 18 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: 8/12/1874
9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Carroll Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John B. Dubs
14. MOTHER'S MAIDEN NAME: Sally Miller

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: John L Dubs Hampstead, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 1 wk.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Hypertension arteriosclerotic Heart Disease — 1 yr

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 11, 1955, to July 18, 1955, that I last saw the deceased alive on July 18, 1955, and that death occurred at 6:50 PM, from the causes and on the date stated above.

SIGNATURE W H Foard (Degree or title) M.D. ADDRESS Manchester, Md DATE SIGNED 7/18/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF July 21 1955 NAME OF CEMETERY OR CREMATORY Lazarus Cemetery LOCATION (City, town, or county) Lineboro (State) Md

DATE REC'D BY LOCAL REGISTRAR July 20-55 REGISTRAR'S SIGNATURE Mrs. Wm. Denner
24. FUNERAL DIRECTOR H. Leifle & Son ADDRESS Glen Rock, Pa
H. Leifle

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06594

65 0

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1 y 4 m 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Caroline
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgely, Md. 05X-2
STREET ADDRESS (If rural give location) Route 1

3. NAME OF DECEASED (Type or Print): (First) Norman (Middle) Irl (Last) Dudman

4. DATE OF DEATH: (Month) 7 (Day) 1 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: 6 - 30 - 98

9. AGE last birthday: 57 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Dudman

14. MOTHER'S MAIDEN NAME: Anna Crouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unkn

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.0 (A) Infarction of myocardium — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (B) DUE TO: (B) Coronary thrombosis — 1 day

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (1026x) DUE TO: (C) Arteriosclerotic heart disease — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chron.br.syndr.assoc.with CNS syphilis Syphilitic aortitis, meningoencephalitis — years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION with psychotic reaction

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 7, 1955, to July 1, , 1955 that I last saw the deceased alive on July 1, 1955, and that death occurred at 10:45 M, from the causes and on the date stated above.

SIGNATURE Edmund Lustbaus M.D. ADDRESS Springfield State Hospital DATE SIGNED July 2, 1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Transportation — DATE THEREOF July 3, 1955 — NAME OF CEMETERY OR CREMATORY Carthage — LOCATION (City, town, or county) Missouri (State)

DATE REC'D BY LOCAL REGISTRAR July 3, 1955 — REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR F. Gasch's Sons — ADDRESS Hyattsville, Maryland.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06505

CERTIFICATE OF DEATH

6511 Reg. Dist. No. 80

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X New Windsor
LENGTH OF STAY (in this place) Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor X
STREET ADDRESS (If rural give location) Route 1

3. NAME OF DECEASED: (Type or Print) (First) ALVIE (Middle) RUSSELL (Last) FLEAGLE
4. DATE OF DEATH: (Month) July (Day) 25 (Year) 1955
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: 2/19/1895
9. AGE last birthday: 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Carpenter Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Fleagle
14. MOTHER'S MAIDEN NAME: Emma Hess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 216-07-4174
17. INFORMANT & ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
502.1
Immediate cause (a) Bronchopneumonia — Interval Between Onset And Death: 3 years
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Chronic Bronchitis — 7 years
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Pulmonary Emphysema

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr ..., 1955, to July 25, 1955, that I last saw the deceased alive on July 23, 1955, and that death occurred at 12 noon, from the causes and on the date stated above.
SIGNATURE James J. Moore (Degree or title) M.D ADDRESS Westminster Md DATE SIGNED 7/26/55

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 7/27/55 — NAME OF CEMETERY OR CREMATORY [illegible] — LOCATION (City, town, or county) (State) [illegible]
DATE REC'D BY LOCAL REGISTRAR 7/26/55 — REGISTRAR'S SIGNATURE Oscar S Bendrat
24. FUNERAL DIRECTOR [illegible] — ADDRESS [illegible]

65 2

06506

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville, Md.
LENGTH OF STAY (In this place) 6 mos. 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore-18, Maryland
STREET ADDRESS (If rural, give location) 2403 North Calvert Street

3. NAME OF DECEASED: (First) LYLE (Middle) (Last) FULLER
4. DATE OF DEATH (Month) 7/ (Day) 6 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married	12/17/00	54 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ~~Maryland~~ Gm Balto Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William L. Langley
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Anna Elizabeth Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary edema	hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Bronchopneumonia	hours
	DUE TO (c) Heat prostration	hours

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Sociopathic personality Disturbance, Alcohol addiction — years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY	21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Mark M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 7/6/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR ~~CREMATORY~~	LOCATION (City, town, or county) (State)
Burial	July 8 1955	Parkwood	Balto. Md

DATE REC'D BY LOCAL REG 7-7-55 | REGISTRAR'S SIGNATURE A. C. Hedrick | FUNERAL DIRECTOR W. M. Jenkins Sons Co | ADDRESS 4905 York Rd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

06507

MARYLAND — **STATE DEPARTMETT OF HEALTH**

65 3

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sykesville
LENGTH OF STAY (in this place): 2 months 13 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural, give location): 807 Grandin Avenue

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Flora	Minerva	Gandy	(July)	28	1955

5. SEX	6. COLOR OR RACE	7. MARRIED, WIDOWED, DIVORCED, Married	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W		6-29-77	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hiram Grady
14. MOTHER'S MAIDEN NAME: Martha — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unkn.
(If year, give war or dates of service):
16. SOCIAL SECURITY NO.: unkn
17. INFORMANT AND ADDRESS: -Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

260X
Immediate cause (a) Myocardial infarction — 2days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic cardiovascular disease — years

(c) Diabetes mellitus — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 18, 1955, to July 28, 1955, that I last saw the deceased alive on July 28, 1955, and that death occurred at 9 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Edmund Lusthaus M.D. — ADDRESS: Springfield State Hospital — DATE SIGNED: July 28, 55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 1, 1955	Rockville Union Cem.	Montgomery Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 28, 1955	C. Harry Hall	Robert G. Pumphrey,	Bethesda, Md.

Item 18 Film Glo6 9-13-55 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06508

65 4

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH.
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Sykesville
LENGTH OF STAY (in this place) 1 mo 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Buckeystown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Ida (Middle) Virginia Weber (Last) Setter

4. DATE OF DEATH. (Month) 7 (Day) 18 (Year) 1955

5. SEX female | **6. COLOR OR RACE** White | **7. SINGLE, MARRIED, WIDOWED, DIVORCED.** (Specify) widowed | **8. DATE OF BIRTH** 2-3-1874 | **9. AGE last birthday** 81 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife | **10B. KIND OF BUSINESS OR INDUSTRY:** | **11. BIRTHPLACE** (State or foreign country) Annie 2 Md | **12. CITIZEN OF WHAT COUNTRY?**

13. FATHER'S NAME: Joseph Frank Weber

14. MOTHER'S MAIDEN NAME: Annie 2

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk | (If Yes, give war or dates of service) | **16. SOCIAL SECURITY NO.** | **17. INFORMANT & ADDRESS:** Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X
IMMEDIATE CAUSE (A) Thrombosis of L posterior cerebral occipital artery — INTERVAL BETWEEN ONSET AND DEATH unknown

ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) Arteriosclerosis, generalized — DUE TO — years
(C) Bronchopneumonia — DUE TO — 36 hrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile brain disease, prostatism

19A. DATE OF OPERATION. | **19B. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | **21B. PLACE** (Home, farm, factory, OF INJURY street, office bldg., etc | **21C. WHERE DID INJURY OCCUR?** (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | **21E. INJURY OCCURRED** While at work ☐ Not while at work ☐ | **21F. HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from 6-6-, 1955 to 7-18, 1955 that I last saw the deceased alive on 7-18-, 1955, and that death occurred at 4:53 P.M., from the causes and on the date stated above.

SIGNATURE Walter H Sommerfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 7/19/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 7/20/55 | NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | LOCATION (City, town, or county) Pikesville, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 7-15-55 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR Wm J Dickens & Sons ADDRESS Balto 17 Md

06509

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6515

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODBINE
LENGTH OF STAY (in this place) 5 MOS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY HOWARD.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MORGAN. 13X-2
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) SARAH (Middle) JANE (Last) GOSNELL

4. DATE OF DEATH: (Month) JULY (Day) 14, (Year) 1955

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOWED

8. DATE OF BIRTH: SEPT. 17, 1866

9. AGE last birthday 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK DAVIS

14. MOTHER'S MAIDEN NAME: ANN DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: MR. EZRA A. GOSNELL. 119 W. SLADE AVE, PIKESVILLE MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
IMMEDIATE CAUSE (A) DUE TO Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH several years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February 1955, to July, 1955, that I last saw the deceased alive on July 14, 1955, and that death occurred at 6.25 P.M., from the causes and on the date stated above.

SIGNATURE W.B. Culwell M.D. ADDRESS Mt Airy, Md DATE SIGNED July 14, 1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL. DATE THEREOF 7-17-55 NAME OF CEMETERY OR CREMATORY MORGAN CHAPEL LOCATION (City, town, or county) (State) WOODBINE, MD.

DATE REC'D BY LOCAL REGISTRAR July 16, 1955 REGISTRAR'S SIGNATURE Robert R. Hewitt. 24. FUNERAL DIRECTOR C.M. Watts ADDRESS Sykesville, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06510

MARYLAND STATE DEPARTMETT OF HEALTH

65 6

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll — Springfield State Hospital. — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 16 mths. 25dys
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital Sykesville, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg 01 X-2
STREET ADDRESS (If rural, give location) Consol Village R.F.D.# 2

3. NAME OF DECEASED (Type or Print): (First) Lucinda (Middle,) (Last) Gracie
4. DATE OF DEATH: (Month) July (Day) 4 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: July 23-85
9. AGE last birthday: 69 yrs. (If under 1 year: Months / Days; If under 24 hrs: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Parker
14. MOTHER'S MAIDEN NAME: Margaret Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowo): No
(If year, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT AND ADDRESS: Mr. Robert Gracie Sr. (Husband) Consol Village RFD#2 Frostburg Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

491X
Immediate cause (a) Bronchopneumonia — days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)....

(c)....

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Chronic Brain Syndrome, with circulatory disturbances. Cerebral arteriosclerosis, with psychotic reaction — years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-9- ., 1953., to 7-4- ., 1955 ., that I last saw the deceased alive on 7-4- ., 1955 , and that death occurred at 9.28 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H. Immenfeldt M D — ADDRESS Springfield State Hospital — DATE SIGNED 7-4-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE 7-7-55 — NAME OF CEMETERY OR CR[illegible] — LOCATION (City, town, or county) (State): Eckert Cemetery Md.

DATE REC'D BY LOCAL REG. July 5, 1955 — REGISTRAR'S SIGNATURE C. Emery Weir — 24. FUNERAL DIRECTOR J. R. Durst - Frostburg Md. — ADDRESS

MARGIN RESERVED FOR BINDING

65 7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06511

Reg. Dist. No. 82-83

Item 10, Filed 8-22-55 e

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; MARYLAND; LENGTH OF STAY (in this place) 50 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS OO

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster X; STREET ADDRESS (If rural, give location) /

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	William	Howard	Hall	July	11	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W	Widowed	July 18, 1889	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Railroad Engineer	B.O.R.R.	Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William G. Hall	Annie E. Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	205-09-1616	Mrs. Anna Hesson - Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial Fibrosis Chron	
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 11, 1955, to July 11, 1955, that I last saw the deceased alive on July 11, 1955, and that death occurred at 7:20 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
C. M. Slaughter M.D.	Mt Airy Md	7/13/55

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-14-55	Loffler Springs	Loffler Springs, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-14-1955	Robert R. Haworth	C. M. Watts	Winfield, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06512

MARYLAND — **STATE DEPARTMETT OF HEALTH**

6512

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY ~~Balto.~~ Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pullum Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore — 3701-4
STREET ADDRESS (If rural, give location) 1624 E. 32nd St.

3. NAME OF DECEASED (Type or Print): (First) Lillian (Middle) I (Last) HARE

4. DATE OF DEATH: (Month) July (Day) 10 (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: July 7, 1882

9. AGE last birthday: 73 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Grocery

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Rudge Hare

14. MOTHER'S MAIDEN NAME: Mary Findley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16. SOCIAL SECURITY NO.: 219-03-4900 A

17. INFORMANT AND ADDRESS: Mrs. Helen L. Nay - 1624 E. 32nd St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

4433 X

Immediate cause (a) Cerebral hemorrhage, arteriosclerosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive cardiovascular disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY ..., 1955, to July ..., 1955, that I last saw the deceased alive on 10 July ..., 1955, and that death occurred at 7 A ...m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Howard E Hall MD — ADDRESS Dyersville, Md — DATE SIGNED 10 July 55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE 7/12/55 — NAME OF CEMETERY OR CREMATORY: Green Mount Cem. — LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG. 7-11-55 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Wm. J. Pickerel & Sons - Balto 17 Md — ADDRESS

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06513

CERTIFICATE OF DEATH

6488

Reg. Dist. No. 36

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 36 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 85 W. Main

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 85 W. Main

27 1

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) SAMUEL (Last) HARMAN

4. DATE OF DEATH: (Month) July (Day) 19 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: Oct. 8, 1865

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer Westminster Shoe Co.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Harman

14. MOTHER'S MAIDEN NAME: Daisy Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-07-3834

17. INFORMANT & ADDRESS: Mrs Edward Brown 85 W. main Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 442X Uremia

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovascular Renal Disease with Heart Block
DUE TO (c)

Interval Between Onset And Death: 2 who over 4 years 4 years

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/8/ 19 55, to 7/19 19 55, that I last saw the deceased alive on 7/18 19 55, and that death occurred at 3:56 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) Allen Morton M.D. ADDRESS Westminster Md DATE SIGNED 7/20/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF July 21, 1955

NAME OF CEMETERY OR CREMATORY Pinedale Cemetery

LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REGISTRAR 7-30-55

REGISTRAR'S SIGNATURE Harriet Miller

24. FUNERAL DIRECTOR J. Bankard & Son Westminster Md.

ADDRESS

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06514

65?9

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH:
COUNTY Carroll Co. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville
LENGTH OF STAY (in this place) 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Linger Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (First) TALBOT (Middle) — (Last) HARRISON

4. DATE OF DEATH: (Month) 7 (Day) 31 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) single

8. DATE OF BIRTH. 10-29- 1871

9. AGE last birthday 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Josiah Harrison

14 MOTHER'S MAIDEN NAME: Elizabeth Burnham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS John Newman, Taneytown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE (A) Cerebral hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: about

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis, Cardiac failure — 6 months

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 31 July, 1955, to 31 July, 1955, that I last saw the deceased alive on 31 July, 1955, and that death occurred at 8:15 PM, from the causes and on the date stated above.

SIGNATURE Howard E Hall M. D. ADDRESS Sykesville, Md. DATE SIGNED 31 July 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

DATE THEREOF 8-3-1955

NAME OF CEMETERY OR CREMATORY County Home

LOCATION (City, town, or county) (State) Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 3, 1955

REGISTRAR'S SIGNATURE Robert R. Hewitt

24. FUNERAL DIRECTOR C. M. Waltz, ADDRESS Winfield, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

06515

MARYLAND — **STATE DEPARTMETT OF HEALTH**

6510

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH · COUNTY: Carroll · MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): 2yrs. 1mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland · COUNTY: Wash.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hagerstown 21-03-2
STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print): (First) Etta (Middle) — (Last) Hartsock
4. DATE OF DEATH: (Month) 7 (Day) 28 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Unknown
9. AGE last birthday: Approx. 93 yrs. (If under 1 year: Months. If under 24 hrs.: Days. Hours. Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Phillip Mathias
14. MOTHER'S MAIDEN NAME: Eleanor Stimmel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Wash.
(If year, give war or dates of service): ——
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

9217
Immediate cause (a) Bronchopneumonia due
Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) to aspiration of gastric material 1 day
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: C.B.S. associated with circulatory disturbance with cerebral arterio. with psychotic reaction. — 2 yrs.

19a. DATE OF OPERATION: ——
19b. MAJOR FINDINGS OF OPERATION: ——
20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ——
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ——
(CITY OR TOWN) (COUNTY) (STATE): ——

TIME OF INJURY (Month) (Day) (Year) (Hour): —— m.
INJURY OCCURRED While at Work [ ] Not While At work [ ]
HOW DID INJURY OCCUR? ——

22. I hereby certify that I attended the deceased from 8-22- ..., 19.53., to 7-28....., 1955., that I last saw the deceased alive on 7-28-....., 19.55., and that death occurred at 3:30 P.m., from the causes and on the date stated above.

SIGNATURE AND TITLE: Florian Nadolski, M.D. (or title) — ADDRESS: Springfield State Hosp., Sykesville, Md. — DATE SIGNED: 7-28-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 7/30/55
NAME OF CEMETERY OR CREMATORY: Mount Olivet Cem.
LOCATION (City, town, or county) (State): Frederick Md

DATE REC'D BY LOCAL REG.: July 29 1955
REGISTRAR'S SIGNATURE: C. Harry Thuer
24. FUNERAL DIRECTOR / ADDRESS: A K Coffman Hagerstown Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06516

6511

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco (Rural)
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco - Rural
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) H (Last) HEWITT

4. DATE OF DEATH: (Month) July (Day) 11 (Year) 1955

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: Apr 14 1886 | 9. AGE last birthday: 70 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Railway Emp.
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Hewitt
14. MOTHER'S MAIDEN NAME: Mary Thayer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mrs Harry H Hewitt, Finksburg Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 X
IMMEDIATE CAUSE (A) Coronary Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Hypertension — 10 yrs
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-10-55, to 7-11-55, that I last saw the deceased alive on 7-10 1955, and that death occurred at 2 M, from the causes and on the date stated above.
SIGNATURE M. C. Porterfield M. D. ADDRESS Hampstead, Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: July 13-55
NAME OF CEMETERY OR CREMATORY: Wesley
LOCATION (City, Town, or county) (State): Carroll Co Md

DATE REC'D BY LOCAL REGISTRAR: 7-14-55
REGISTRAR'S SIGNATURE: Hamet Miller
24. FUNERAL DIRECTOR: Edw C Tipton
ADDRESS: Hampstead Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6512

06517

CERTIFICATE OF DEATH

Reg. Dist. No. ..

1. PLACE OF DEATH: Carroll County — COUNTY — MARYLAND — STATE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (in this place): 43 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hosp;

2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland — STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 855 [illegible]ark Ave.
3 Vol. 4 ✓

3. NAME OF DECEASED (Type or Print): (First) Wm. (Middle) A (Last) Hohlbein

4. DATE OF DEATH: (Month) July (Day) 20 (Year) 1955

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorsed — 8. DATE OF BIRTH: Feb. 7, 1882 — 9. AGE last birthday: 73 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restauranteur — 10B. KIND OF BUSINESS OR INDUSTRY: Restaurant — 11. BIRTHPLACE (State or foreign country): Baltimore Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Hohlbeim — 14. MOTHER'S MAIDEN NAME: Mary Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no — (If Yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: none — 17. INFORMANT & ADDRESS: Hosp. Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE — (A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arrested Pulmonary Tuberculosis — years

DUE TO (C) Coronary Thrombosis — 1 day

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Dementia Precox, paranoid type — 43 years

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 24, 1912 to July 20 1955, that I last saw the deceased alive on July 20, 1955, and that death occurred at 7:35 PM, from the causes and on the date stated above.

SIGNATURE: Gertrud Sonnenfeldt M.D. — ADDRESS: Springfield State Hospital Sykesville Md — DATE SIGNED: 7-20-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 7/23/55 — NAME OF CEMETERY OR CREMATORY: Lorraine Cem. — LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR: 7/22/55 — REGISTRAR'S SIGNATURE: U. W. Hedrick — 24. FUNERAL DIRECTOR: Wm. J. Tichener & Sons — ADDRESS: Balto 17 Md

Item 18 Film G184 8-2-55 ams 6513

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06518

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Springfield Hosp. Hate
LENGTH OF STAY (in this place) 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sykesville

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 18
STREET ADDRESS (If rural give location) 1623 Ralworth Rd.

3. NAME OF DECEASED (Type or Print): (First) Ellen (Middle) Elizabeth (Last) House House
4. DATE OF DEATH: (Month) 7 (Day) 22 (Year) 1955

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):
8. DATE OF BIRTH: 1-31-87
9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife
10B. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Baltimore ?
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Kaiser /
14. MOTHER'S MAIDEN NAME: Catherine Conroy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Thrombosis
IMMEDIATE CAUSE: 422.1
DUE TO
ANTECEDENT CAUSE (B): long standing cardiovascular disease
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST: CBS & marked Arterio-sclerosis
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Parkinsonism & psychotic Reaction

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-26, 1955, to 7-22, 1955, that I last saw the deceased alive on 7-21, 1955., and that death occurred at 5:45 a.M, from the causes and on the date stated above.

SIGNATURE — ADDRESS — DATE SIGNED
Gertrud Sonnenfeldt M.D. Springfield State Hospital Sykesville Md.

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: July 25, 1955
NAME OF CEMETERY OR CREMATORY: New Cathedral
LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR: July 23 1955
REGISTRAR'S SIGNATURE: K.C.
24. FUNERAL DIRECTOR — ADDRESS: Lilly & Zeiler Inc., 403 S. Wolfe St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06519

6514

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Finksburg,
LENGTH OF STAY (in this place) 12 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Finksburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown
STREET ADDRESS (If rural give location) 101 Butler Road

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) George (Last) Jeffers

4. DATE OF DEATH. (Month) July (Day) 10, (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: July 14, 1871

9. AGE last birthday: 83 yrs | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10B. KIND OF BUSINESS OR INDUSTRY: General Medicine

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Jeffers

14. MOTHER'S MAIDEN NAME: Ann Catherine Pumphrey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs. John Jeffers - 101 Butler Rd. Reisterstown, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X IMMEDIATE CAUSE	(A) Cerebral hemorrhage	15 hours
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 260X1	(B) DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Diabetes	10 mos.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.): none

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State): none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): none M.

21E. INJURY OCCURRED While at work ☐ none Not while at work ☐

21F. HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from Dec. 15, 1945, to July 10, 1955, that I last saw the deceased alive on July 10, 1955, and that death occurred at 9:30P M, from the causes and on the date stated above.

SIGNATURE D. D. Eaples — ADDRESS M. D. Reisterstown, Md. — DATE SIGNED 7-11-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/12/55	All Saints Cem.	Reisterstown, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-12-55	A. W. Hedrich	Wm. J. Tipton & Sons	Davis 17 Md

06520

MARYLAND 6515

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville; MARYLAND; LENGTH OF STAY (In this place) 49 y 1 m 22 d; HOSPITAL OR INSTITUTION OR STREET ADDRESS State Springfield Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Balto City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; 3 Vol 4; STREET ADDRESS (If rural, give location) 4020 Cranston Avenue

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Louis (Last) Justi

4. DATE OF DEATH: (Month) 7 (Day) 9 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 1 - 1 - 1866

9. AGE last birthday: 89 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY: Hosp.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Justi

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Tickner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unkn (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422 Immediate cause (a) Arteriosclerotic Cardiovascular Disease — years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arterisclerosis — years

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Paranoid condition — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1955, to July 9, 1955, that I last saw the deceased alive on July 9, 1955, and that death occurred at 5:45 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Edmund Lusthaus M.D. ADDRESS Springfield State Hospital DATE SIGNED July 9,55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE 7/12/55 NAME OF CEMETERY OR CREMATORY: Loudon Park Cem. LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG. 7-11-55 REGISTRAR'S SIGNATURE C

24. FUNERAL DIRECTOR: Wm. J. Tickner & Sons ADDRESS: Balto 17, Md

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06521

6516

CERTIFICATE OF DEATH

Reg. Dist. No. ....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 6/3/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3701-4
STREET ADDRESS (If rural give location) 534 N. Decker AVENUE ✓

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) --- (Last) KANZLER

4. DATE OF DEATH: (Month) July (Day) 29 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: January 14, 1902

9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10B. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William Kanzler

14. MOTHER'S MAIDEN NAME: Sadie McElwee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (S): DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST 025X

(B) Bilateral artery thrombosis in the brain — 3-4 days

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with meningo-encephalitic syphilis — 3 years

19A. DATE OF OPERATION: ---

19B. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from June 30, 1953, to July 29 1955, that I last saw the deceased alive on July 29, 1955, and that death occurred at 5:00AM, from the causes and on the date stated above.

SIGNATURE Martin Gross, M. D. ADDRESS Sykesville, Maryland DATE SIGNED 7/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Aug. 1, 1955

NAME OF CEMETERY OR CREMATORY Baltimore Cemetery

LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE ✓

24. FUNERAL DIRECTOR ADDRESS John A. Moran 3000 E. Baltimore St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06522

6517

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Hyksville
LENGTH OF STAY (in this place) 25 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyksville X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Ella (Middle) - (Last) Keefer

4. DATE OF DEATH: (Month) 7 (Day) 24 (Year) 1955

5. SEX: F. | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed | 8. DATE OF BIRTH: Dec. 10, 1874 | 9. AGE last birthday 80 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: Home | 11. BIRTHPLACE (State or foreign country): Md. | 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jonathan M. Owings | 14. MOTHER'S MAIDEN NAME: Anna Rebeca Sommers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) - | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS: Mrs Nona Thomas - Hyksville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (B) DUE TO Cerebral hemorrhage — 2 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Generalized arteriosclerosis — 20 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 23, 1955, to July 24, 1955, that I last saw the deceased alive on July 24, 1955, and that death occurred at 11:55 PM from the causes and on the date stated above.
SIGNATURE Bertrand R. Gaer M. D. ADDRESS SYKESVILLE Md DATE SIGNED 7-25-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 7-27-55 | NAME OF CEMETERY OR CREMATORY Baile | LOCATION (City, town, or county) (State) M New Windsor, Md.

DATE REC'D BY LOCAL REGISTRAR July 26, 1955 | REGISTRAR'S SIGNATURE C. Harry Wm | 24. FUNERAL DIRECTOR Luther H. Haight | ADDRESS Hyksville, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

6518 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06523

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville, Md.
LENGTH OF STAY (in this place) 4 m 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 01-02-2
STREET ADDRESS (If rural give location) 602 Shriver Ave.

3. NAME OF DECEASED: (Type or Print) (First) Flora (Middle) May (Last) Kifer

4. DATE OF DEATH: (Month) 7 - (Day) 3 - (Year) 1955.

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married | 8. DATE OF BIRTH: 10 - 19 - 1880 | 9. AGE last birthday 74 yrs. | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Millard Filmore Wagner
14. MOTHER'S MAIDEN NAME: Amanda —— ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. unkn.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
053.0 IMMEDIATE CAUSE	(A) Septicemia	2 weeks
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Pyelitis due to Non hemolytic streptococ. & Escher.coli	2 weeks
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Chronic brain syndr. ass. with senile brain disease with psychotic reaction	years

19A. DATE OF OPERATION. | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1- , 1955 to 7 - 3 - , 1955, that I last saw the deceased alive on July 3, 1955, and that death occurred at 1:15 PM, from the causes and on the date stated above.

SIGNATURE Edmund Lustbaum M. D. ADDRESS Springfield Hospital DATE SIGNED July 3, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 7-7-55 | NAME OF CEMETERY OR CREMATORY Cumberland | LOCATION (City, town, or county) (State) Allegany Co. Md.

DATE REC'D BY LOCAL REGISTRAR July 5, 1955 | REGISTRAR'S SIGNATURE C. Stacey Oliver | 24. FUNERAL DIRECTOR Louis Stein Inc. | ADDRESS Cumberland, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

06524

6519

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 80

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Westminster | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Minster X
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CHARLES	C	LEMMON	July	10	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	If under 1 year Months	Days	If under 24 hrs Hours	Min.
Male	White	Married	11/11/12					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Carpenter	Retired	Md	U.S.

13. FATHER'S NAME — 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		219 01-1767	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

976X **Immediate cause** (a) GUNSHOT WOUND OF CHEST — minute

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Field	(CITY OR TOWN) New Windsor	(COUNTY) Carroll	(STATE) Md

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐	Not while at work ☒	HOW DID INJURY OCCUR?
7	10	55	12:10 A.m.			SHOT GUN WOUND

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James J. Thorsch	Deputy Medical Examiner	Westminster Md	7-10-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	7-12-55	Baust Reformed	Union Bridge	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 11-1955	Ernest L. Benedict For		

06525

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6520

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ■g■ is especially important. Physicians: ple■se write the ■■ues ■f death ■l■rly ■nd legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Manchester — LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Long View nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE md. — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN manchester — X
STREET ADDRESS (If rural give location) 9 Church St — 1

3. NAME OF DECEASED: (Type or Print) (First) Lena (Middle) E. (Last) Lippy
4. DATE OF DEATH: (Month) 7 (Day) 17 (Year) 1955

5. SEX: Fem
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: 4/27/68
9. AGE Last birthday: 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Carroll Co md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Christian Hunt
14. MOTHER'S MAIDEN NAME: Annie C Hashman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Harry Lippy 204 York St manchester md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) 263X Arteriosclerotic Heart Disease — 5 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Diabetes — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 3/8/48, to 7/17/55, that I last saw the deceased alive on 7/17/55, and that death occurred at 10:40 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
W H. Foard M D. — Manchester Md — 7/17/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 7/20/55 — NAME OF CEMETERY OR CREMATORY Reformed Church Cem — LOCATION (City, town, or county) (State) Manchester Carroll Co Md

DATE REC'D BY LOCAL REGISTRAR 7/19-55 — REGISTRAR'S SIGNATURE Mrs. W.P. Lenner

24. FUNERAL DIRECTOR — ADDRESS
Frederick Bucher Hanover Pa

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06526

6521

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED: (Type or Print) (First) Rose (Middle) Irma (Last) Mastin

4. DATE OF DEATH: (Month) July (Day) 17 (Year) 1955

5. SEX: F.

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 12-14-1893

9. AGE last birthday: 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis P. Maguire

14. MOTHER'S MAIDEN NAME: Rose M. Dellenmiller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Dr. M. N. Mastin, Sykesville, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175 X
IMMEDIATE CAUSE (A) General Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Adeno-carcinoma of ovary — 12+ mos
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 June, 1955, to 17 July, 1955, that I last saw the deceased alive on 17 July 1955, and that death occurred at 12 Noon M, from the causes and on the date stated above.

SIGNATURE O. K. Laurent M. D. | ADDRESS Sykesville, Maryland | DATE SIGNED 7-17-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 7-19-55 | NAME OF CEMETERY OR CREMATORY Woodlawn | LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR July 18, 1955 | REGISTRAR'S SIGNATURE C. Harry Eiler | 24. FUNERAL DIRECTOR Luther N. Haight | ADDRESS Sykesville, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06527

CERTIFICATE OF DEATH

6522 Reg. Dist. No. 76

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS R 4 Reese

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
STREET ADDRESS (If rural give location) R 4 Reese

3. NAME OF DECEASED: (Type or Print) (First) Jessie (Middle) Rhodes (Last) Matthews

4. DATE OF DEATH: (Month) July (Day) 16 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 6, 1869

9. AGE last birthday: 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Nelson Matthews

14. MOTHER'S MAIDEN NAME: Sophia Rhodes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) - - - - - -

16. SOCIAL SECURITY NO.: - - - - - - - - -

17. INFORMANT & ADDRESS: Mrs. Edward Knox Gamber, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of stomach DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) — DUE TO

(c) —

Interval Between Onset And Death Probably 6 mos.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) — (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from May 16, 1955, to June 14, 1955, that I last saw the deceased alive on June 14, 1955, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. Billingslea M.D. Westminster, Md. 7-18-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF July 19, 1955

NAME OF CEMETERY OR CREMATORY Westminster

LOCATION (City, town, or county) (State) Westminster Md.

DATE REC'D BY LOCAL REGISTRAR 7-18-55

REGISTRAR'S SIGNATURE Harriet Grimes

24. FUNERAL DIRECTOR John R. Byers ADDRESS Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06528

6523

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll Co. MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN X Union Mills
LENGTH OF STAY (in this place) 6 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Meadow View Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural give location) 31 Westminster St

3. NAME OF DECEASED: (Type or Print) (First) HARRIET (Middle) MATILDA (Last) MALS

4. DATE OF DEATH: (Month) July (Day) 11 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: July 18, 1877

9. AGE Last birthday: 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob H. Babylon

14. MOTHER'S MAIDEN NAME: Sarah Reinhart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Mrs. F. Gilds, Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebro Vascular Accident — Interval Between Onset And Death: 2 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Arteriosclerotic Hypertension Cerebro Vascular Renal Insufficiency. — Chronic

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/29 ..., 1949, to 7/11 ..., 1955, that I last saw the deceased alive on 7/5 ..., 1955, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Helen Mallo MD ADDRESS Westminster Md DATE SIGNED 7/12/55

26. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 7/14/55

NAME OF CEMETERY OR CREMATORY Pedro Cemetery

LOCATION (City, town, or county) (State) Near Westminster Md

DATE REC'D BY LOCAL REGISTRAR 7-13-55

REGISTRAR'S SIGNATURE Harold Miller

24. FUNERAL DIRECTOR J. E. Myers, Jr.

ADDRESS Westminster Md

VS. A15

06529

MARYLAND — **STATE DEPARTMETT OF HEALTH**

6524

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY CARROLL — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (In this place) 24 Y, 2 M, 15D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Unknown Baltimore City
STREET ADDRESS unknown (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Jones (Last) MORRIS

4. DATE OF DEATH: (Month) 7 (Day) 20, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 6/12/71

9. AGE Last birthday: 84 yrs. — If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk (rtd)

10b. KIND OF BUSINESS OR INDUSTRY: Savings Bnk of Balto

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas H. Morris

14. MOTHER'S MAIDEN NAME: Sallie H. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Coronary occlusion	Instantaneous
Antecedent cause(s)	(b) Arteriosclerotic heart disease	4 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (or 2)	(c) Pulmonary tuberculosis, inactive	years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Manic-depressive reaction, manic phase	24 yrs

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1/54, 19....., to 7/20, 19 55, that I last saw the deceased alive on 7/19, 19 55 and that death occurred at 11:30 (DST) A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS — DATE SIGNED
Walter H Sonnenschein M D Springfield State Hospital 7/19/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 7/22/55 — NAME OF CEMETERY OR CREMATORY: Green Mount Cem. — LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG: 7/22/55 — REGISTRAR'S SIGNATURE: A. M. Hedrick — FUNERAL DIRECTOR: Wm. J. Tiefner & Sons — ADDRESS: Balto 17 Md

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06539

CERTIFICATE OF DEATH

6525 Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
LENGTH OF STAY (in this place) 72 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pleasant Valley

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster Rt #2
STREET ADDRESS (If rural give location) Pleasant Valley

3. NAME OF DECEASED: (Type or Print) (First) DAVID (Middle) LEROY (Last) MYERS

4. DATE OF DEATH: (Month) July (Day) 9 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 26, 1883	72 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Painter & Farmer		Pleasant Valley Md.	U. S. A.

13. FATHER'S NAME: David D. Myers

14. MOTHER'S MAIDEN NAME: Mary Jane Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT'S ADDRESS:
No		—	Mrs D. R. Myers Westminster, Md. R.D.#2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO Cerebral Hemorrhage — Interval Between Onset And Death: March 19, 1951

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO Hypertension & Arteriosclerosis — 6 yrs.
(c)

443X

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 19, 1951, to July 9, 1955, that I last saw the deceased alive on July 9, 1955, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) William Speicher - md — ADDRESS Westminster Md — DATE SIGNED July 9-1955

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 12, 55	Pleasant Valley Cemetery	Pleasant Valley Carroll Co. Md.

DATE REC'D BY LOCAL REGISTRAR 7-9-55 — REGISTRAR'S SIGNATURE Hazel Miller

24. FUNERAL DIRECTOR J. E. Myers, Jr. — ADDRESS Westminster Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

06531

MARYLAND STATE DEPARTMENT OF HEALTH

6526

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Westminster R.F.D. 2 | LENGTH OF STAY (In this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pleasant Valley

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Westminster R.D. 2 X
STREET ADDRESS (If rural, give location) Pleasant Valley

3. NAME OF DECEASED (Type or Print): (First) ISAAC. (Middle) HERMAN (Last) MYERS.

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 6 1894

9. AGE last birthday: 61 yrs. | If under 1 year: Months | Days | If under 24 hrs: Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer own farm

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levi Myers

14. MOTHER'S MAIDEN NAME: Etta Rinehart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-20-0438

17. INFORMANT AND ADDRESS: Ruth Myers Westminster R.D. 2 Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: Months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

420.1

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection X Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ___, suicide ___, homicide ___, undetermined ___.*

SIGNATURE: James J. Mook (Degree or title) M.D. ADDRESS: Baltimore Md. DATE SIGNED: 7/28/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: July 30 1955 | NAME OF CEMETERY OR CREMATORY: Pleasant Valley Memorial Park | LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REG. 7-29-55 | REGISTRAR'S SIGNATURE: Hamit Miller | 24. FUNERAL DIRECTOR: A. Rinehart & Son | ADDRESS: Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

06532

6527

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 80

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor — LENGTH OF STAY (In this place) 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	GEORGE	FRANKLIN	PETRY	July	7	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last Birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
male	white	married	2/26/1903	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter Paperhanger	Owner	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank Petry	Pearl Eckert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	218-32-3451	Mrs. Petry, New Windsor, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) Coronary Occlusion	Several yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary artery disease	Several yrs.
(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul J. Brand	Deputy Med. Examiner	Westminster Md	7/5/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	7/8/55	Winters Cemetery	Carroll County	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 7, 1955	Cora Benedict	C. O. Hartzler & Son	New Windsor, Md.

VS. A15A

06523

6523

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead Rural
LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead Rural
STREET ADDRESS (If rural, give location) Upperco, Rd. Md.

3. NAME OF DECEASED (Type or Print): (First) Jacob (Middle) Fulton (Last) Roop
4. DATE OF DEATH: (Month) July (Day) 9 (Year) 1955

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 1888-3-18
9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Franklin Pierce Roop
14. MOTHER'S MAIDEN NAME: Ida Sedenia Bond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-34-6665
17. INFORMANT AND ADDRESS: Sallie Roop (wife) Upperco, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Sudden

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last: (b) Severe Dyspepsia (Angina Pectoris) — 1 year
(c) Strenuous work Arteriosclerosis — 30 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 3, 1955, to Mar 3, 1955, that I last saw the deceased alive on Mar 3, 1955, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Cyril E. Forrest M.D. Upperco Md. July 9-55

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE (OF) July 12-1955 — NAME OF CEMETERY OR CREMATORY Emory — LOCATION (City, town, or county) (State) Carroll Co Md

DATE REC'D BY LOCAL REG. 7/9/55 — REGISTRAR'S SIGNATURE Henry Reese

24. FUNERAL DIRECTOR — ADDRESS Edw C Tipton — Hampstead Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06534

6529

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 1 y 9 m 23 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Vol 4
STREET ADDRESS (If rural give location) Unk - 1

3. NAME OF DECEASED: (First) Elizabeth (Middle) (Last) Schaffer
4. DATE OF DEATH: (Month) 7 (Day) 31 (Year) 55
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: 1873 ?
9. AGE last birthday: 82 ? yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): not known
10b. KIND OF BUSINESS OR INDUSTRY: Unk -
11. BIRTHPLACE (State or foreign country): not known
12. CITIZEN OF WHAT COUNTRY? ?
13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: not known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk -
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

420.0
Immediate cause (a) Myocardial infarction — 2 days
DUE TO
Antecedent causes (b) Arteriosclerotic heart disease — years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO
9 mo 7
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. C.B.S. due to senile brain changes Fracture of right hip — 2 years - 2 m 3 days

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ward
(CITY OR TOWN) Springfield State Hospital (COUNTY) (STATE)
TIME OF INJURY (Month) 5 (Day) 28 (Year) 55 (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☒
HOW DID INJURY OCCUR? Patient fell while walking

22. I hereby certify that I attended the deceased from 5-29-1955, to 7-31-1955, that I last saw the deceased alive on 7-30-1955, and that death occurred at 1:45 a.m., from the causes and on the date stated above.
SIGNATURE Edmund Leuthauser (Degree or title) M.D. ADDRESS Springfield State Hospital DATE SIGNED 7-31-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Aug. 1 1955
NAME OF CEMETERY OR CREMATORY Loudon Park
LOCATION (City, town, or county) (State) Baltimore, Md.
DATE REC'D BY LOCAL REGISTRAR July 31, 1955
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR W. E. Cook, Inc.
ADDRESS 1217 W. Fayette St. Balto. Md.

VS. A15

06535

MARYLAND

STATE DEPARTMETT OF HEALTH

6530

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville; MARYLAND; LENGTH OF STAY (in this place) 28 y 4 m 1 d; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clarksburg; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Annie; (Middle); (Last) SCHLERETH

4. DATE OF DEATH: (Month) (July) (Day) 30 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: about 1902

9. AGE last birthday: about 53 yrs. If under 1 year: Months; Days; If under 24 hrs: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore County ?

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If year, give war or dates of service)

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pyrexia of unknown origin — Interval Between Onset and Death: 3 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) (Bacteriological and Serological tests - negative)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Dementia Praecox, Catatonic type, — 28yrs.+

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 11, 1955, to July 30, 1955, that I last saw the deceased alive on 7-30- 1955, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus (Degree or title) M.D. ADDRESS Springfield State Hospital DATE SIGNED July 30,55

Edmund Lusthaus M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: 8-3-55; NAME OF CEMETERY OR CREMATORY: Springfield; LOCATION (City, town, or county) (State): Sykesville, Md.

DATE REC'D BY LOCAL REG.: Aug. 2, 1955; REGISTRAR'S SIGNATURE: C. Henry Kerr; 24. FUNERAL DIRECTOR: Luther H. Haight; ADDRESS: Sykesville, Md

06536

MARGIN RESERVED FOR BINDING

MARYLAND

STATE DEPARTMETT OF HEALTH

6531

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 12 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural, give location) 3025 Windsor Avenue

3. NAME OF DECEASED (Type or Print) (First) Catherine (Middle) Teresa (Last) Schmidt

4. DATE OF DEATH (Month) 7 - (Day) 30 - (Year) 1955

5. SEX Bemale

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 3 - 1 - 76

9. AGE last birthday 79 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unkn

10b. KIND OF BUSINESS OR INDUSTRY Unk.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Myyers

14. MOTHER'S MAIDEN NAME Margaret Scholte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unkn (If year, give war or dates of service)

16. SOCIAL SECURITY No. unkn

17. INFORMANT AND ADDRESS Hospital R cords

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

49-X

Immediate cause (a) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 13 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Chron.Brain Syndr.assoc.with disturb.of metab.growth or nutr.with senile brain dis.with psych.react. — one year

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No X

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 - 17 - , 1955 , to 7 - 30 - , 1955 , that I last saw the deceased alive on 7 - 30 - , 1955 , and that death occurred at 9:15 P.m., from the causes and on the date stated above.

SIGNATURE W. H. Sonnenfeldt (Degree or title) ADDRESS Springfield State Hospital DATE SIGNED 7-31-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE 8-3-55 NAME OF CEMETERY OR CREMATORY Holy Redeemer LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. July 31, 1955 REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR Edward J. Rauch ADDRESS 5305 Harford Rd.

07626

MARYLAND — STATE DEPARTMETT OF HEALTH

6532

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH: COUNTY Carroll — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville, Md — MARYLAND — LENGTH OF STAY (in this place) — HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Howard — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville Maryland X — STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) — (Last) SEAL

4. DATE OF DEATH: (Month) July (Day) 9 (Year) 1955

5. SEX: M — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): —

8. DATE OF BIRTH: Dec 7 1880 — 9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — 10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Louisville Tennessee — 12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Francis Seal

14. MOTHER'S MAIDEN NAME: Ruth Cantwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS: Eva Jeffries Brookville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X

Immediate cause (a). Cardiac arrest, Uremia, Anemia,

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of Stomach & generalized

(c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: April 55 — July 55

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1955, to July, 1955, that I last saw the deceased alive on July 9, 1955, and that death occurred at 7 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Harold E Hall MD — ADDRESS Sykesville Md — DATE SIGNED July 9 55

23. BURIAL, CREMATION, REMOVAL? (Specify) Sec to Cemetery — DATE — NAME OF CEMETERY OR CREMATORY Deals Home Cemetery — LOCATION (City, town, or county) Elkhorn Md (State)

DATE REC'D BY LOCAL REG. Aug. 23, 1955 — REGISTRAR'S SIGNATURE C Harry Beers

24. FUNERAL DIRECTOR — ADDRESS Roy W. Barber Laytonsville 1119

MARGIN RESERVED FOR BINDING

I

6533

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06537

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 8/15/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
STREET ADDRESS (If rural give location) 6540 Lenhart Drive

3. NAME OF DECEASED: (Type or Print) John (First) Peter (Middle) SHIELDS (Last)

4. DATE OF DEATH: July (Month) 20 (Day) 1955 (Year)

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: January 21, 1894

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business manager -

10B. KIND OF BUSINESS OR INDUSTRY: Unk-

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Daniel Shields

14. MOTHER'S MAIDEN NAME: Mary Alice - ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
IMMEDIATE CAUSE (A) Arteriosclerotic heart disease — more than 4 yrs
ANTECEDENT CAUSE (B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C) Old cerebral thrombosis — more than 4 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: ---

19B. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ---

21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Feb. 12 1954, to July 20, 1955, that I last saw the deceased alive on July 20 ..., 1955, and that death occurred at 10:45 P M, from the causes and on the date stated above.

SIGNATURE Martin Gross M. D. Martin Gross, M. D. M. D. ADDRESS Sykesville, Maryland DATE SIGNED 7/21/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF July 25, 1955 — NAME OF CEMETERY OR CREMATORY Cedar Hill — LOCATION (City, town, or county) (State) Suitland Md.

DATE REC'D BY LOCAL REGISTRAR July 22, 1955 — REGISTRAR'S SIGNATURE C. Harry Weber

24. FUNERAL DIRECTOR Francis J. Collins ADDRESS 3821-14 St. N.W. Wash. D.C.

06538

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6434

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 47 Carroll Street
MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Gertrude (Middle) M. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year): July 5, 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Oct. 5, 1877

9. AGE last birthday: 77 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Petry

14. MOTHER'S MAIDEN NAME: Harriet Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: H. Stewart Smith, Westminster, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.1 Immediate cause	(a) Coronary Thrombosis	Several Years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension Coronary Sclerosis	20 yrs
	(c) Obesity	Yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 19 34, to July 5, 19 55, that I last saw the deceased ~~alive~~ dead on July 5, 1955, and that death occurred at 7:30 A. m., from the causes and on the date stated above.

SIGNATURE: William Spencker (Degree or title) ADDRESS Westminster Rd DATE SIGNED July 6-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: July 8, 1955

NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

LOCATION (City, town, or county) (State): Westminster, Maryland

DATE REC'D BY LOCAL REG. 7-7-55

REGISTRAR'S SIGNATURE: Harriet Miller

24. FUNERAL DIRECTOR ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

06533

6534

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 80

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY [illegible] MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]; LENGTH OF STAY (in this place) 4 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] COUNTY [illegible]; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]; STREET ADDRESS (If rural give location) [illegible]

3. NAME OF DECEASED (Type or Print): (First) NORMAN (Middle) LEE (Last) SMITH

4. DATE OF DEATH: (Month) [illegible] (Day) [illegible] (Year) 19[illegible]

5. SEX: [illegible]

6. COLOR OR RACE: [illegible]

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): [illegible]

8. DATE OF BIRTH: [illegible]

9. AGE last birthday: [illegible] yrs. If under 1 year: Months [illegible] Days [illegible]; If under 24 hrs.: Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS, OR INDUSTRY: Chemical

11. BIRTHPLACE (State or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): [illegible]

16. SOCIAL SECURITY NO.: 229-28-6018

17. INFORMANT AND ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 420.1 Myocardial Infarction — Interval between onset and death: 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary Sclerosis — 1 month

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: [illegible]

19b. MAJOR FINDINGS OF OPERATION: [illegible]

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): [illegible]

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: [illegible] (CITY OR TOWN) [illegible] (COUNTY) [illegible] (STATE) [illegible]

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: [illegible]

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? [illegible]

22. I hereby certify that I attended the deceased from June 21, 1955, to July 20, 1955, that I last saw the deceased alive on July 20, 1955, and that death occurred at 3:40 A m., from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) MD ADDRESS [illegible] DATE SIGNED 7/[illegible]/55

23. BURIAL, CREMATION, REMOVAL (Specify): [illegible] DATE THEREOF [illegible] NAME OF CEMETERY OR CREMATORY [illegible] LOCATION (City, town, or county) [illegible] (State) [illegible]

DATE REC'D BY LOCAL REG. July 31-1955

REGISTRAR'S SIGNATURE Erica S Benedict

24. FUNERAL DIRECTOR [illegible] ADDRESS [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06540

6535

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Alesia
LENGTH OF STAY (in this place) 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Alesia
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) CHARles (Middle) H. (Last) Spicer

4. DATE OF DEATH: (Month) July (Day) 18 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 6 1878

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Owner

10b. KIND OF BUSINESS OR INDUSTRY: Gen'l. Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John W. Spicer

14. MOTHER'S MAIDEN NAME: Elizabeth Krok

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No.

16. SOCIAL SECURITY NO.: 720-09-6607

17. INFORMANT & ADDRESS: Chas. W. Spicer, Hampstead Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerosis — Interval Between Onset And Death: 5 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Heart Disease

DUE TO (c) Thrombosis at femoral artery — 3 mos

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov ..... ,1950., to July 18., 1955., that I last saw the deceased alive on July 17., 1955, and that death occurred at 12:55 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) W. H. Hoard M.D. ADDRESS Manchester, Md DATE SIGNED 7/18/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF July 20/55

NAME OF CEMETERY OR CREMATORY Lutheran Cemetery LOCATION (City, town, or county) (State) Manchester, Carroll Co. Md

DATE REC'D BY LOCAL REGISTRAR July 18-55

REGISTRAR'S SIGNATURE Mrs. W. H. Hoard

24. FUNERAL DIRECTOR Edw. C. Tipton ADDRESS Hampstead, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06541

6435

CERTIFICATE OF DEATH

Reg. Dist. No. 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 27 Westminster

LENGTH OF STAY (in this place): 30 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 02 S. Colonial Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster

STREET ADDRESS (If rural give location): S. Colonial Avenue

3. NAME OF DECEASED: (Type or Print) (First) Gladys (Middle) Estella (Last) Sprinkle

4. DATE OF DEATH: (Month) July (Day) 19 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	May 8, 1900	55 yrs.		

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife	Own home	Patapsco, Maryland	USA

13. FATHER'S NAME: Milton Barrick

14. MOTHER'S MAIDEN NAME: Millie Mabbett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no - - - -	- - - - - - -	Mrs. Kenneth A. Sprinkle Westminster, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause — (a) Coronary Occlusion (Coronary attack for 10 days) — Interval Between Onset And Death (Few min.)

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) Cardio-vascular disease with hypertension 10 yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
—				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

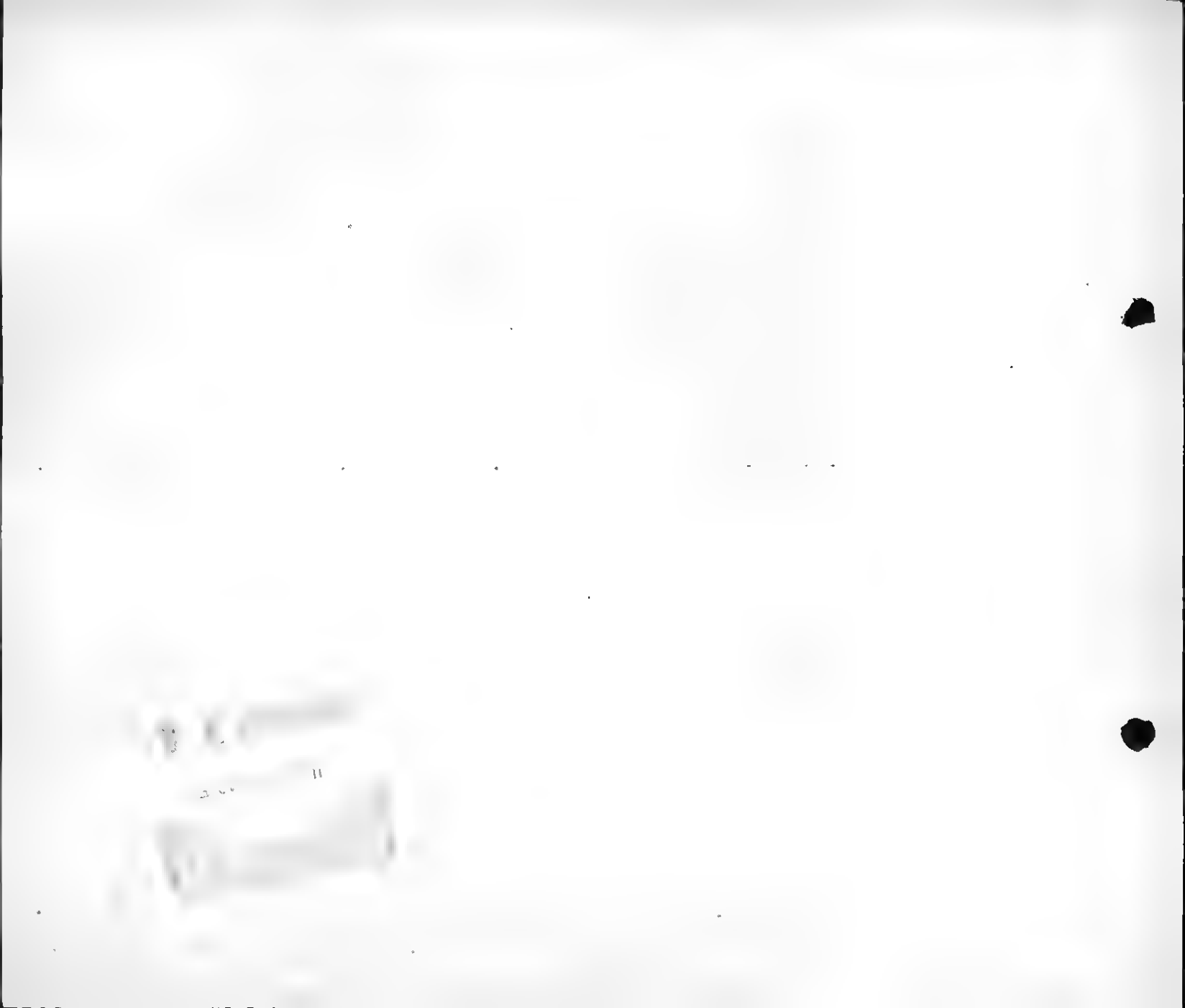
22. I hereby certify that I attended the deceased from Jan. 15, 1946, to July 18, 1955, that I last saw the deceased alive on July 18, 1955, and that death occurred at 2 p. m., from the causes and on the date stated above.

SIGNATURE: C. T. Billingslea — (Degree or title) M. D. — ADDRESS: Westminster, Md. — DATE SIGNED: 7-20-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 22, 55	Westminster	Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-21-55	Harriet Miller	John R. Byers	Westminster, Md.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06542

6536

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1 PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL) OR TOWN Sykesville
MARYLAND
LENGTH OF STAY (in this place) 1 y 11 m 2 d
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laytonsville, Md.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) Milton (First) Walker (Middle) Strothers (Last)

4. DATE OF DEATH: (Month) 7 (Day) 3 (Year) 1955.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 1870 (?)
9. AGE last birthday: 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. Strothers
14. MOTHER'S MAIDEN NAME: Matilda Heflin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn (If Yes, give war or dates of service) unkn.
16. SOCIAL SECURITY NO. unkn.
17. INFORMANT & ADDRESS. Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
IMMEDIATE CAUSE (A) Cerebral hemorrhage due to hypertension — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSE (B) DUE TO: Arteriosclerotic heart disease — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) 1936 (?)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndr. assoc. with cerebr. arteriosclerosis — years

19A. DATE OF OPERATION: 7-1-55
19B MAJOR FINDINGS OF OPERATION: Severe traumatic rupture of right eyeball Enucleation of right eye
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) S.S. Hospital, Sykesville, Md.
21D TIME OF INJURY (Month) 6 (Day) 26 (Year) 55 (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? Pt. was hit in the eye with a fist by a fellow patient

22. I hereby certify that I attended the deceased from 6-26-1955, to 7-2-1955, that I last saw the deceased alive on 7-2-1955, and that death occurred at 5:45A M. from the causes and on the date stated above.

SIGNATURE Walter H. Tommasulat M.D. ADDRESS Springfield State Hospital DATE SIGNED July 3, 1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF July 6-1955
NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery
LOCATION (City, town, or county) (State) Montgomery County

DATE REC'D BY LOCAL REGISTRAR July 4/1955
REGISTRAR'S SIGNATURE C. Stacy Eckert
24. FUNERAL DIRECTOR Robert C. Young Sr. & Jr.
ADDRESS Brookeville, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

6537

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 17632

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Sykesville, Md.
LENGTH OF STAY (in this place) 9 y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Catherine (Middle) Jean (Last) Suddeth

4. DATE OF DEATH: (Month) 7 (Day) 30 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): | 8. DATE OF BIRTH 7-2-02 | 9. AGE last birthday 53 yrs | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible] Wm. Nave | 14. MOTHER'S MAIDEN NAME: Susan Rebecca Crider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS: Hospital Record

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 420.1
(A) Coronary Occlusion
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Hypocardial Degeneration with Arteriosclerosis
DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Syphilitic Meningo-Encephalitis

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-29, 1946, to 7-30, 1955 that I last saw the deceased alive on 7-30, 1955, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

SIGNATURE, ADDRESS, DATE SIGNED: Gertrud Sonnenfeldt M.D. Springfield State Hospital Sykesville Md.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)
Cremated | Aug 1 1955 | Univ. of Md. Med. Sch. | Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR: Aug 24, 1955 | REGISTRAR'S SIGNATURE: C. Harry Young | 24. FUNERAL DIRECTOR: The Anatomy Board, Md. John M. Christ | ADDRESS

06543

MARYLAND

STATE DEPARTMETT OF HEALTH

6538

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Finksburg
LENGTH OF STAY (In this place) 3 [illegible]
HOSPITAL OR INSTITUTION OR STREET ADDRESS Manchester Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg X
STREET ADDRESS (If rural, give location) Gamber Road

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) Holt AND8 (Last) [illegible]AO.E.S

4. DATE OF DEATH: (Month) [illegible] (Day) [illegible] (Year) 1955

5. SEX: [illegible]

6. COLOR OR RACE: [illegible]

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): [illegible]

8. DATE OF BIRTH: [illegible]

9. AGE last birthday: [illegible] yrs. If under 1 year: Months [illegible] Days [illegible] If under 24 hr: Hours [illegible] Min [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]

10b. KIND OF BUSINESS OR INDUSTRY: [illegible]

11. BIRTHPLACE (State or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: - unknown

14. MOTHER'S MAIDEN NAME: - unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): World War No 1

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X

Immediate cause (a) [illegible]

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ..... (c) .....

INTERVAL BETWEEN ONSET AND DEATH: [illegible]

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 1955, and that death occurred at [illegible] m., from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) ADDRESS [illegible] DATE SIGNED [illegible]

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 7/13/55

NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem.

LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG. 7-11-55

REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR: Wm. J. Palmer & Sons-Baltimore, Md.

ADDRESS

6539 06544

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville
LENGTH OF STAY (in this place) 5Y 8 Mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Chevy Chase
STREET ADDRESS (If rural, give location) 4826 Leland Street

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Edward (Last) WEIGEL

4. DATE OF DEATH (Month) 7 (Day) 29 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 6/10/76

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Income tax confrere

10b. KIND OF BUSINESS OR INDUSTRY: Treasury Dept.

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALBERT ~~George~~ Weigel

14. MOTHER'S MAIDEN NAME: BARBARA — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Subdural and intracerebral hemorrhage	12 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO arteriosclerosis	years
	(c) DUE TO Bronchopneumonia	days

331X

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic brain syndrome associated with senile brain disease, with psychotic reaction — 8 years

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James C. Farrell M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 7, 29/55

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation
DATE THEREOF 7-30-55
NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory
LOCATION (City, town, or county) Prince George's (State) Md.

DATE REC'D BY LOCAL REG. July 29, 1955
REGISTRAR'S SIGNATURE C. Harry Tucker

24. FUNERAL DIRECTOR Robert A. Pumphrey
ADDRESS Bethesda, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6540

CERTIFICATE OF DEATH

06545

Reg. Dist. No. 14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural - Sykesville
LENGTH OF STAY (in this place): 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Washington — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hagerstown 21-03-2
STREET ADDRESS (If rural give location): 20 S. Cannon Avenue

3. NAME OF DECEASED: (First) MYRTLE (Middle) VIOLA (Last) WILLIAMS

4. DATE OF DEATH: (Month) 7 (Day) 6 (Year) 19 55

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Div.

8. DATE OF BIRTH: 9/15/84

9. AGE last birthday: 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Otha Mongan

14. MOTHER'S MAIDEN NAME: Mary Moats

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk — (If Yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk -

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Bronchopneumonia — 5 days
DUE TO
Antecedent causes (b) Arteriosclertic heart disease — years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO
(c) Generalized arteriosclerosis — years

420.0

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — 2 years?

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-1, 19 55, to 7-6, 19 55, that I last saw the deceased alive on 7-5, 19 55, and that death occurred at 2:9 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Walter H. Counterfelt M.D. Springfield State Hospital 7/6/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 7-9-55

NAME OF CEMETERY OR CREMATORY: Manor

LOCATION (City, town, or county) (State): Mt. Tilghmanton, Md.

DATE REC'D BY LOCAL REGISTRAR: July 6, 1955

REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: B. R. Coffman

ADDRESS: Hagerstown, Md.

6541 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 D6546

Item 9, FilmG185 8-26-55 et CERTIFICATE OF DEATH Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Uniontown
LENGTH OF STAY (in this place) 4yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Uniontown
STREET ADDRESS (If rural give location) Rural

3. NAME OF DECEASED: (Type or Print) (First) ELWOOD (Middle) SNADER (Last) ZOLLICKOFFER

4. DATE OF DEATH: (Month) July (Day) 22 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 9/21/1892
9. AGE last birthday: 62 yrs. M B
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): farmer
10b. KIND OF BUSINESS OR INDUSTRY: owner
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Milton Zollickoffer
14. MOTHER'S MAIDEN NAME: Ida Snader

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes World War I
16. SOCIAL SECURITY No.: 217-09-2044
17. INFORMANT & ADDRESS: Gertrude Zollickoffer, Uniontown, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: Sudden

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) multiple Arthritis — years
DUE TO (c)

725 X

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19 51, to July 23, 1955, that I last saw the deceased alive on 7-23-, 1955, and that death occurred at 1:30 A M, from the causes and on the date stated above.
SIGNATURE (Degree or title) J. Hugg M D ADDRESS Union Bridge DATE SIGNED 7-23-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 7/25/55
NAME OF CEMETERY OR CREMATORY Methodist Cem.
LOCATION (City, town, or county) (State) Uniontown, Md.

DATE REC'D BY LOCAL REGISTRAR 7/23/55
REGISTRAR'S SIGNATURE Margaret R. Englar
24. FUNERAL DIRECTOR / ADDRESS D. D. Hafflich & Sons New Windsor, Md.

VS. A15